Meeting Minutes
Health Information Technology Council Meeting

June 3, 2013
3:30 – 5 p.m.

One Ashburton Place, 21th floor Matta Conference Room
Boston, MA

Meeting Attendees

Name	Seat	Organization	Attended
John Polanowicz	Secretary of Health and Human Services or Designee (Chair)	*Secretary of the Executive Office of Health and Human Services*	Yes
Manu Tandon	Secretary of Health and Human Services or Designee (Chair)	*Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator*	Yes
John Letchford (Designee for Glen Shor)	Secretary of Administration and Finance or Designee	*Chief Information Officer, Commonwealth of Massachusetts*	Yes
David Seltz	Executive Director of the Health Policy Commission or Designee	Executive Director of Health Policy Commission	Yes[1]
Aron Boros	Executive Director of the Center for Health Information Analysis (CHIA)	*Executive Director of Massachusetts Center for Health Information and Analysis*	Yes[2]
Laurance Stuntz	Director of the Massachusetts e-Health Institute	*Director, Massachusetts eHealth Institute*	Yes
Eric Nakajima	Secretary of Housing and Economic Development or a Designee	*Assistant Secretary for Innovation Policy in Housing and Economic Development*	No
Julian Harris, MD	Director of the Office of Medicaid or Designee	*Director of Office of Medicaid*	No
Meg Aranow	Expert in Health Information Technology	*Senior Research Director, The Advisory Board Company*	Yes
Deborah Adair	Expert in Health Information Privacy and Security	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Yes
John Halamka, MD	From an Academic Medical Center	*Chief Information officer, Beth Israel Deaconess Medical Center*	Yes
Normand Deschene	From a Community Hospital	*President and Chief Executive Officer , Lowell General Hospital*	No
Jay Breines	From a Community Health Center	*Executive Director, Holyoke Health Center*	Yes
Robert Driscoll	From a Long Term Care Facility	*Chief Operations Officer, Salter Healthcare*	Yes
Michael Lee, MD	From a Large Physician Group Practice	*Director of clinical Informatics, Atrius Health*	Yes
Margie Sipe, RN	Registered Nurse	*Nursing Performance Improvement Innovator, Lahey Clinic*	Yes
Steven Fox	Representative of health insurance carriers	*Vice President, Network Management and Communications,*	Yes

[1] Patricia Boyce was a proxy for David Seltz
[2] Aron Boros was in attendance by phone

Name	Seat	Organization	Attended
		Blue Cross Blue Shield MA	
Larry Garber, MD	Experience or Expertise in Health Information Technology	*Medical Director of Informatics, Reliant Medical Group*	Yes
Karen Bell, MD	Experience or Expertise in Health Information Technology	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Yes
Kristin Madison	Expert in Law and Health Policy	*Professor of Law and Health Sciences, Northeastern School of Law, Bouvé college of Health Sciences*	Yes
Daniel Mumbauer	From a Behavioral Health, Substance Abuse Disorder or Mental Health Services Organization	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	Yes

Other:

Name	Organization
Erich Schatzlein	Massachusetts eHealth Collaborative (MAeHC)
Carol Jeffery	Massachusetts eHealth Collaborative (MAeHC)
Kimberly Gross	Executive Office of Health and Human Services
Brian Sandager	Lowell General Hospital
Clark Fenn	Holyoke Medical Center
Carl Cameron	Holyoke Medical Center
Pam May	Partners Healthcare
Micky Tripathi	Massachusetts eHealth Collaborative (MAeHC)
David Swim	MHA
Kathleen Snyder	Executive Office of Health and Human Services
Sean Kennedy	Massachusetts eHealth Institute (MeHI)
Ian Rowe	Orion Health
Mark Belanger	Massachusetts eHealth Collaborative (MAeHC)
Lisa Fenichel	E-Health Consumer Advocate
Nick Welch	Executive Office of Health and Human Services
Robert McDevitt	Executive Office of Health and Human Services
Kimberly Haddad	Executive Office for Administration and Finance (ANF)

Meeting Minutes:

Meeting called to order – minutes approved

The meeting was called to order by Secretary John Polanowicz at 3:32 pm.

Council reviewed minutes of the May 6th, 2013 HIT Council meeting. The minutes were approved as written.

Discussion Item 1: Mass HIway Implementation Updates (Slides 3-16)

See slides 3-16 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides

Holyoke Medical Center – Presented by Holyoke Medical Center Chief Information and Analytics Officer, Carl Cameron (slides 4-14)

(Slide 5-14) The council was briefed on the HealthConnect Clinical Data Exchange project underway at Holyoke Medical Center. Please see the slides for full details on the process and discussion.

(Slide 5) Background – The Council was briefed on the background of Holyoke Medical Center including details on population served, hospital capabilities, and group memberships.

(Slide 6) Vision for an Integrated Healthcare System - The Council was briefed on the relationships Holyoke Medical Center maintains with the healthcare community.

(Slide 7) Holyoke HealthConnect Solution – Integrates HealthConnect exchange with eClinicalWorks (eCW) and Meditech EHR systems so physicians never have to seed Continuity of Care Documents (CCDs) into the exchange. Tiani Spirit software was used to interface eCW to the exchange and Iatric Systems was used to interface with Meditech.

(Slide 8) Holyoke HealthConnect Requirements – The council reviewed slide content.

- Question (Secretary Polanowicz): Have you had to terminate participation for any organizations? Or, have you had to provide any "slap on the wrist" to participants?
    - Answer (Carl Cameron): Participation and transactions are closely monitored and there has not been a need to terminate participants or provide any disciplinary action at this time.

(Slides 9-10) HealthConnect Implementation Status – The council reviewed slide content.

(Slide 11) HealthConnect and the Mass HIway – Integration between the Holyoke HealthConnect exchange and the Mass HIway is in progress. Successful transactions have been exchanged, and future testing will occur with other HIway partners in the near future. An implementation grant was secured to connect behavior health providers with the HIway.

(Slide 12) Lessons Learned – Lack of industry standards for connecting EHRs, and slow vendor responses throughout the process can impede progress. Education was needed for changing mindset of physicians to have them understand that clinical documentation would be viewable to others. Documentation must be viewable and actionable for the next person who will see the documentation. Approximately 10-15% of CCDs that were available in the exchange are being viewed by providers.

- Question (Secretary Polanowicz): Please clarify the percentages of information being viewed.
    - Answer (Carl Cameron): There are approximately 250,000 documents available, and only about 10-15% of what is available is being viewed.
    - Comment (John Halamka). The workflow for providers to view the documents can be an impediment. However, the current industry standard matches the approximate 10-15% view rate. Another barrier may be providers not willing to look for information due to low match rates, or having to log-in to separate systems.
- Question (Laurance Stuntz): Will Holyoke Medical Center need to change consent form content to comply with the Mass HIway?
    - Answer (Carl Cameron): It is unclear at this time if changes will be needed on the consent form. Examples and guidance would be helpful for making the determination to meet best practices.
- Question (Karen Bell): What type of consent is being used now, opt-in or opt-out?
    - Answer (Carl Cameron): Whether opt in or opt out, the patient record goes to the clinical data repository. Patients may then opt-in at each practice to allow the physician to view information that is available in the repository. This allows for the repository to be used for population health analytics using de-identified data. The opt-in form is the same for all locations.
- Question (Deborah Adair): What information is included for the opt-in consent? Does the opt-in include sensitive information such as HIV results?
    - Answer (Carl Cameron): It is all in or all out.
- Question (Laurance Stuntz): Will the practices still treat the patient if the patient opts-out?
    - Answer (Carl Cameron): Yes, treatment is provided for patients regardless of the exchange consent preferences.
- Question (Larry Garber): Do you get opt-in one time and maintain that until patient revokes?
    - Answer (Carl Cameron): Yes

(Slide 13) HealthConnect Data Model - The council reviewed slide content.

- Question (Secretary Polanowicz): Are hospital consult notes available?
    - Answer (Carl Cameron): Currently only CCDs are available. Consult notes from Meditech are next as are additional document types. The goal is to have more documentation available out of the Emergency Department.

(Slide 14) HIE Patient Consent Workflow - The council reviewed slide content.

- Question (Deborah Adair): Is the consent process electronic or an automated consent model?
    - Answer (Carl Cameron): The standard Integrating the Healthcare Enterprise (IHE) framework for electronic consent is used. The exchange consolidates the organization consent information into a single repository.
- Question (Michael Lee): If a practice sends CCD each time a patient is seen, how do you handle multiple ccds? Do they merge?
    - Answer (Carl Cameron): Provider sees 2 separate ccds – we don't consolidate these. The CCDs have dates and times to identify the most recent CCD available. The responsibility of medication reconciliation still falls on the physician.
- Question (Larry Garber) – Are exchange participants able to incorporate CCDs stored in the exchange into EHRs?
    - Answer (Carl Cameron): Yes, participants can download CCDs into Meditech.

- Question (Karen Bell): Is the exchange using the same Master Patient Index (MPI) as the HIway, or will it integrate with the HIway?
    - Answer (Carl Cameron): Testing is still in process at this point, and a determination cannot be made yet.
- Comment (Karen Bell): There are some national-level efforts underway, such as between Healtheway, the Interoperability Work Group, and the Certification Commission for Health Information Technology (CCHIT), that may help accelerate standards refinement and adoption.
- Question (Larry Garber): What has been the level of effort for to prepare and maintain the exchange MPI?
    - Answer (Carl Cameron): The process has been manageable and hasn't been too labor intensive thus far. Advanced patient matching algorithms are in place and reports are run frequently to verify accuracy. There have not been any major issues. There was a lot of control when rolling out the MPI, but anticipate issues when connecting to additional organizations.
- Question (Deborah Adair): Did Holyoke Medical Center need to add staff for the MPI work?
    - Answer (Carl Cameron): A dedicated staff person for interface and MPI work was a new addition to the team.

Beth Israel Deaconess Medical Center – Presented by Beth Israel Deaconess Medical Center Chief Information Officer, John Halamka (slides 15-16)

(Slide 16) The council was briefed on the Mass HIway implementation progress at Beth Israel Deaconess Medical Center. Please see the slides for full details on the process and discussion.

In addition to the slide content, John Halamka discussed an update on the patient consent process: Beth Israel Deaconess Medical Center (BIDMC) has posted signs to notify patient they may opt-out of having their information shared. "Patient has not opted-out" is in the current literature. Information will always be shared with the Department of Public Health (DPH), but patients can opt-out of DPH sharing the information with others.

- Question (Deborah Adair): Don't you have to send information to DPH?
    - Answer (John Halamka): Consent is not required to send information to DPH. However, DPH does need consent to share the information with others such as school nurses. This consent is stored in a flag sent with the data to DPH.
- Question (Laurance Stuntz): Have any patients chosen to opt-out?
    - Answer (John Halamka): No patients have opted-out at this time.

John summarized progress: Now sending 4,000 transactions per day to the MAeHC quality data center. Have successfully filed all Accountable Care Organization (ACO) reports. Latency is less than 1 second per transaction and robust. The process took 1 year for modifications with eCW to capture consent at registration. BIDMC is using an "opt-in to disclose" approach. BIDMC is planning to change the Notice of Privacy Practices (NPP) to include mention of the Mass HIway as a means for sharing information and will leave the consent to treat/consent to disclose patient information as is.

- Question (Laurance Stuntz): Tiani Spirit used IHE profile for consent with Holyoke. Are you using the same standard?
    - Answer (John Halamka): The standard is not robust and has not been widely adopted. BIDMC has not adopted, and HIway will likely take a different approach.

- Question (Deborah Adair): Does the BIDMC consent to treat document contain reference to the Mass HIway?
    - Answer (John Halamka): BIDMC is leaving the consent to treat form as is but is modifying the NPP to indicate the Mass HIway will be used as a means for sharing information.
- Question (Larry Garber): Once an organization has updated the NPP, is the organization required to have patients sign the new version?
    - Answer (Micky Tripathi): Healthcare treatment organizations only need to have patients sign the updated NPP on an ongoing basis as the patient is seen again for treatment. Payer organizations have different requirements.
- Question (Meg Aranow): What is the audit process?
    - Answer (John Halamka): BIDMC uses a random audit process. Compliance staff randomly reviews access history to ensure individual accessing patient information are involved in care. Given heightened sensitivity of the Boston Marathon incident, the importance of the audit process was highlighted as questions arose of who should have been accessing the suspects' records. The audit process is manual right now because automated process cannot determine appropriate access. We are now looking into products to help with audit.

John mentioned that 57% of Beth Israel Deaconess providers access prior patient information during a patient visit.

- Question (Robert Driscol): Why is it 57% compared to 10-15% at Holyoke (referencing earlier presentation from Holyoke)?
    - Answer (John Halamka): We have done a lot to push the physicians on this. We have also built the functionality into the software and workflow.
    - Comment (Michael Lee): This is not an "apples to apples" comparison - There is a much richer data set for physicians to look at beyond the CCD such as results, notes, and other documents.

This is still evolving as a science – for example the ccd doesn't yet include a pre-natal screening sheet.

- Question (Deborah Adair): Did you say it is an opt-out?
    - Answer (John Halamka): The consent process is an opt-in to disclose information
- Question (Karen Bell): The BIDMC consent process is currently predicated on Direct and Phase 1 capabilities. Has any thought been given to Phase 2 consent?
    - Answer (John Halamka): BIDMC has been thinking forward to Phase 2 consent for the HIway. For example, providing HIV results would be impossible with the current consent process since consent would be required at every encounter. A different consent approach will be required for Phase 2 services.

Discussion Item 2: Advisory Group Discussion & Updates presented by the Massachusetts eHealth Collaborative CIO Micky Tripathi (slides 17-24)

See slides 17-24 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides

(Slide 18) May Advisory Group Meetings - The council was provided with an update on May Advisory Group Meeting. The primary focus of the meetings is to discuss key issues in the Mass HIway planning process and seek advice from the group members.

(Slides 19-20) HIway Participation Models – The presentation and discussion of participation models was intended to inform the council of potential options, but not to seek a recommendation from the council.

Vendor HIEs are cutting across state lines, and vendors are also indicating that the Mass HIway will have to cross the vendor networks to connect with client organizations. The HIway is currently facing policy and technology questions regarding how to connect users on vendor exchanges. If the HIway connects any users on a vendor exchange, does that mean that the HIway will need to connect all organizations within the vendor exchange?

The council was briefed on Direct Participation and Cross-Network Participation models for organizations to connect to the HIway. There may be an opportunity in the future to leverage national approach for connecting users to HIEs. DirectTrust.org is attempted to resolve issues and move toward a national model, but is more of a framework than a solution right now. The HIway may not have much to gain by joining a network like DirectTrust.org. The HIway would need to create individual contracts with different networks, which is not scalable for the future if done on an individual basis.

- Question (Karen Bell): DirectTrust.org has large grant from ONC and they are being encouraged to get certified. Where do you see the program going?
    - Answer (Micky Tripathi): Only about 4 organizations have certified as of last week (referring to the EHNAC HIE Accreditation Program) and Surescripts is the only one of those that is a player in our market. It is unclear how the continued development will solve the HIway's problems "on the ground." Chapter 224 requires an opt-in process for the Mass HIway, but DirectTrust doesn't include that requirement in the design. Differences like this example will be present between networks. How will the HIway be able to determine if other networks participating with DirectTrust also comply with the HIway requirements? The HIway will still need to negotiate with other networks individually.

(Slide 21) Advisory Group Discussion – The council reviewed the questions discussed with Advisory Groups during the May meetings.

- Question (Larry Garber): Does DirectTrust have any relation for provider directories?
    - Answer (Micky Tripathi): No, DirectTrust manages security and authenticates users.
    - Comment (Michael Lee): The fear in the community is that a fake health care organization could potentially gain access to HIEs and patient information. Provided an example of "Mike's fake healthcare organization" and how it could be authenticated but should definitely not be given access
    - Comment (John Halamka): The HIway had a potential user apply for access, but the provider currently does not have a MA medical license and was denied membership.

(Slide 22) Phase 1 Consent Clarification - There is currently confusion in the community about the consent requirements for the HIway. The language in Chapter 224 is the root of the confusion. Please see slide content for full details.

(Slide 23) Making the Opt-in Requirement Operational – The council reviewed the slide content for Phase 1 consent straw-man. Phase 2 consent will require a separate discussion and requirements for additional features.

- Comment (Deborah Adair): The community would find it helpful if a better interpretation was made of the Chapter 224 requirements. If patients take exception to the consent procedures for the HIway, they will quote the law and language about opt-out and opt-in. It would be best to have model language available.
    - Response (Micky Tripathi): We could offer up examples like the BI example or EOHHS could give organizations guidance
- Comment (Larry Garber): Clarity of the type of information that could be shared, genetic testing etc… could be modeled with best practice example.
    - Response (Micky Tripathi): Phase 1 consent mirrors the information sharing practices already in place – I'm not sure that we want to get into areas beyond HIway consent.
- Question (Mike Lee): If EOHHS makes a guideline, is legislature going to want to be involved?
    - Answer (Secretary Polanowicz): There would be a process for it – we would be very clear regarding the legislative intent, call out the changes since the legislation was passed, promulgate regulations, and involve legislators in the process.
    - Comment (Micky Tripathi): We should use caution around using legislative process.
- Comment (Aron Boros): Suggested that the HIT council be used as the publisher model language on consent practices instead of EOHHS. This would provide guidance as endorsed by the HIT council, but not as official language of EOHHS.
- Question (Karen Bell): There are differences between HIway CCD transactions and fax/phone options. When physicians receive information through the HIway, they can incorporate the information into EHRs as structured data. They may also pick and choose which information is incorporated into EHR, or decide not incorporate at all. How do we tell patients what will happen with information when it gets to the receiver?
    - Answer (Micky Tripathi): The options for incorporating information into a patient record are the same as what happens today. The HIway is simply used to deliver the materials to the receiver, and what the receiver does is up to that particular person or organization.
    - Comment (Kathleen Snyder): The Participation Agreement that each organization signs to connect to the HIway addresses this.

Discussion Item 3: MeHI FY14 Operating Plan presented by Massachusetts eHealth Institute Director, Laurance Stuntz (slides 25-29)

See slides 25-29 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Chapter 224 requires that MeHI seeks review and comments from HIT council on the budget and plan. MeHI will have a board meeting in late June for review and potential approval.

(Slide 27) Key Planned Activities – The council reviewed the planned activities presented on the slide.

- Question (Meg Aranow) – Does MeHI have any responsibilities for the licensure requirement in Chapter 224?
    - Answer (Laurance Stuntz): The licensing board has the authority to renew, and determine the requirements. MeHI's role is not to define the regulation, but to educate

and explain the requirements to providers. MeHI is also involved in determining which providers and organizations have adopted EHRs, and who needs help.
    - Comment (Michael Lee): This is really scary. For example, if a new provider comes into the state or comes directly out of med school or is a PCP without enough Medicaid patients to certify for meaningful use, they can't obtain a license without EHR experience.
    - Comment (Laurance): We are starting to work with the Board of Registration in Medicine (BORIM) to help them understand the magnitude of the problem, for example, how many pediatricians are there in the state who don't qualify for the Medicaid program and how many residents are there annually. There are likely to be different answers for different groups regarding how a provider can prove they are a meaningful user of an EHR without having a formal certification from the Medicare or Medicaid program.

(Slides 28-29) MeHI Program and Funding Evolution – The council was briefed on the current programs and funding sources at MeHI.

MeHI will be seeking comments and questions on the budget and plan presentation. Additionally, MeHI will be reaching out to organizations one-on-one to solicit feedback.

- Question (Secretary Polanowicz): Do you need a formal HIT Council vote?
    - Answer (Laurance Stuntz): The legislation says that we only need review and comment from the Council
- Question (Secretary Polanowicz): Can you ask the MeHI counsel if a vote is needed?
    - Answer (Laurance Stuntz): Our counsel confirmed this already.
- Comment (Secretary Polanowicz): The ONC grant funding is running out in February. Based on MeHI's current projection, it seems like we will have to spend like we have never spent before in order to avoid giving funds back. Will we be able to get there?
    - Response (Laurance Stutz): Yes, there is lots of backlog to be funded. There is some risk that we will not be able to spend all funds.
- Question (Secretary Polanowicz): Can you provide dashboards for where we are on a monthly basis? We don't want to get to December and realize that we need to give funds back.
    - Answer (Laurance Stuntz): Yes, we can do that.
- Question (Karen Bell): What is the timeline for getting comments to you?
    - Answer(Laurance Stuntz): Comments back this week – we will be incorporating them next week

Discussion Item 4: Mass HIway Update (slides 30-37)

See slides 30-37 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides

Sales & Outreach Update – Presented by the Director of Health Information Exchange at MeHI, Sean Kennedy (slides 31-33)

(Slide 31) HIway Interface Development Grants - The grant program is looking to attract all types of systems and vendors. This will be the second round of grants available. The potential funding to participants has been doubled and restrictions have been reduced to increase participation.

(Slide 32) HIway Implementation Grants – The slide map displays the locations of the awarded grantees. The council was provided a brief explanation of the plans for some organizations participating in the grant program.

- Question (John Halamka): Can you share a list of the vendors with the HIT Council?
  - Answer (Sean Kennedy): Yes

(Slide 33) Sales Dashboard – The council reviewed the slide content and available statistics.

Implementation, Support & Phase 2 Update – Presented by the Executive Office of Health and Human Services CIO, Manu Tandon (slides 34-37)

(Slide 34-35) Implementation – Manu Tandon provided an update on the implementation status of organizations participating in the Mass HIway. The discussion included key organization updates, use cases, and status/target dates. Please see slide content for full details.

(Slide 36) Support – The council reviewed the slide content and available statistics.

(Slide 37) Phase 2 overall timeline – Please see slide for current timeline updates.

Discussion Item 5: Wrap-up and next steps (slides 38-40) presented by EOHHS CIO, Manu Tandon

See slides 38-40 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides

The next HIT Council meeting is July 1st on the 21st floor. Please refer to information posted to the web site. The preliminary agenda for the next Council meeting was reviewed.

For future meetings, the HIT Council will continue to ask customers to participate and provide updates on implementation.

Secretary Polanowicz requested that council members submit comments this week to Laurance Stuntz on the MeHI budget and plan. He also asked that consent be discussed further by the Council.

The HIT Council meeting was adjourned at 5:10pm.